Q&A Session for Lower GI 2

June 1, 2023

#	Question	Answer
1.	Need to review the entire imaging report to look for LN. Often times if LN is not mentioned in impression section they are mentioned in the details/body of imaging report.	Excellent point! I should have mentioned that too!! In this example lymph nodes were not mentioned at all, which sometimes happens when distant mets is noted, they just stop mentioning the other things....
2.	Are the tables Denise has made included in the slides from the webinar?	Yes
3.	It is helpful to put on a different "thinking cap" when doing AJCC staging as there can be different definitions of "treatment" for staging classifications than what is coded as tx per STORE/SEER in other data items.	That is true, always consult the appropriate manual for abstracting various fields & follow the instructions appropriate for that field.
4.	I copied the slide from NRCA and it says, "MD ordered tests but results were not clear." I would think this is perfect example of being unclear.	If you are referring to Poll 8 regarding T3/T4 disease, Donna's presentation states *registrars are to assign a blank when physicians use uncertainty rule with main categories (e.g. T3/T4).* These instructions are also reinforced in the AJCC Curriculum for Registrars lesson 9: Correct T category for uncertain information for Registrars- registrars are to assign a blank.
5.	I thought it was TX when the physician didn't know. To me, it sounds like the physicians discussed the results from the imaging and they still don't know if this is T3 or T4, therefore the physician doesn't know. The investigation was done though.	It's a subtle difference, but referring to the slides by Donna Gress at the NCRA Conference this year, an X would be assigned when physicians are clear they do not know, in the example for Poll 8, the physician was using the uncertainty rule with the main categories (e.g. T3/T4) so we were instructed to use a blank. These instructions are also reinforced in the AJCC Curriculum for Registrars lesson 9: Correct T category for uncertain information for Registrars- registrars are to assign a blank.
6.	cTX does apply at times for colon when it's not possible for even physicians to determine T:	That is correct, for example when only a colonoscopy is performed, a colonoscopy cannot tell how far through the wall the tumor extended. These instructions are also reinforced in the AJCC Curriculum for Registrars

	https://cancerbulletin.facs.org/forums/node/125493 https://cancerbulletin.facs.org/forums/node/128582	lesson 9: Assign an X when diagnostic workup did not provide info needed to assess and assign T category- Example: colonoscopy for colon cancer.
7.	I thought cTX was reserved for when the physician did something(imaging/exam/scope) to assess the tumor but was unable to fully assess it to assign a T value. If there was nothing done to assess, then it is blank. For prostate we were told no DRE=no clinical T(blank). It is very confusing because the Canswer forum responses are contradicting themselves. Donna has given different answers for the same questions as well.	Per Donna Gress presentation at NCRA in SanDiego this year *AJCC Staging: Understanding New Content & Clarification of Staging Issues*, slide twenty-seven. Registrars • **Assign X** • Physicians are clear they do not know • Physicians have not or could not assess primary tumor or nodes • Physicians have assessed but results did not provide any information • **Assign blank** • Registrar does not have info, but physician might • Physician using uncertainty rule with main categories (e.g. T3/T4) As far as the DRE goes, clinical T is based on the information gathered from the DRE. If you know for an absolute fact that the DRE was NOT done, then you can assign a cTX. If you are unsure if it was performed or not and the physician did not document one way or another, you will assign a cT BLANK.
8.	Poll 11 Canswer has stated that a CT can't provide a cT for lower T cancers of the colon.	Agreed. The CAnswer Forum is where we got our information to assign cTX for that case example.
9.	This was an update in CAnswer Forum 1/11/22 regarding Blank vs X.	The post that I found illuminating on the new thinking for Blank vs X came from a CAnswer forum post dated 3-26-2021 http://cancerbulletin.facs.org/forums/forum/ajcc-tnm-staging-8th-edition/lower-gastrointestinal-tract-chapters-19-21/colon-and-rectum-chapter-20/114814-rectal-uncertain-clinical-t-and-group-stage
10.	If a LAMN is staged as a T3 or T4 on pathology would that mean it's invasive and captured as /3?	Yes. LAMN can be /2 or /3. They are assigned /2 as long as they are confined to the muscularis. If they invade beyond the muscularis propria, they are no longer considered to be /2 in situ. Donna Gress confirmed this during Part 1 of the Lower GI webinar series.
11.	According to FORUM, LAMN and HAMN are graded according to low grade and high grade as stated. However, the grade table for colon doesn't allow	**This CAnswer Forum post has been updated to let us know if the pathologist does not assign a grade, we assign G1 to LAMN and G2 to HAMN. This is per page 20 in the AJCC Appendix Cancer Staging Protocol.**

	generic grade, so how do you code grade for LAMN, as low grade, without the option in the grade table? https://cancerbulletin.facs.org/forums/forum/site-specific-data-items-grade-2018/general-instructions/139427-coding-the-grade-when-its-part-of-the-histology#post139441	
12.	I think the fact is that the physician knows that the lesion is 'at least' a T3.	Poll 8- yes, the physician is applying the uncertainty rule T3/T4, registrars are to assign a BLANK.
13.	Can you post the link to Lesson 9 of the AJCC curriculum?	This is the link to Cancer Registrar Education available on the ACS website. Click on the AJCC Curriculum for Registrars tab & you will see all the Modules and lessons. https://www.facs.org/quality-programs/cancer-programs/american-joint-committee-on-cancer/staging-education/registrar/
14.	I would like to know when we only have a polypectomy which is performed (as a treatment), meets the criteria for pathological TNM, how is the pN category assigned? pNX (unknown as the grouping stage) or can we use the cN0 and assign the grouping stage?	For colon/rectal cancer if the case were in situ, you could use cN0, but if it is not, you would use pNX. We cannot mix pT and cN0 except for pTis (any site), pT1 (melanoma skin), and the sites listed in Node Status document which can be found at https://www.facs.org/media/qpygzrh5/node_status_not_required_rare_circumstances.pdf
15.	Our colon screening program has indicated a shift in clinical practice whereby colonoscopy with a complete excision (excisional biopsy) is now being encouraged reducing the need for wider resection. What impact will this have on assigning cT? (NB: there is frequently no depth of invasion)	If the depth of invasion is not available, it would be assigned a cTX.
16.	Low grade and high grade are the difference between LAMN and HAMN. it is not the histologic grade. That is why there is a SSDI to tell you whether it is a LAMN or HAMN	Yes, HAMN and LAMN have the same histology code of 8480; the SSDI "histologic subtype" is used to differentiate.
17.	An appendectomy is done and a LAMN is incidentally found that is T4a, margins were positive. The	That particular CAnswer Forum post was for a 2022 Appendix case. I would need to know the date of diagnosis in order to answer this question

	Physician states they felt it was resected and that further intestinal resection would not be indicated. Would the case qualify for path staging? I am questioning based on this CAnswer Forum post: https://cancerbulletin.facs.org/forums/forum/ajcc-tnm-staging-8th-edition/lower-gastrointestinal-tract-chapters-19-21/appendix-carcinoma-chapter-19/136140-incidental-finding-of-lamn-pt4a#post139758	appropriately. For cases diagnosed 2023+refer to AJCC Appendix: Version 9 of the AJCC Cancer Staging System. For diagnosis date 2018-2022 refer to AJCC 8th Edition.
18.	Per the histology subtype SSDI LAMN is described as "low grade (well diff) appendiceal adenocarcinoma". Does that mean for LAMN we would code grade as G1 well diff?	If the pathologist does not assign a grade for LAMN or HAMN, we are allowed to assign G1 to LAMN and G2 to HAMN. This is per an updated CAnswer Forum post at https://cancerbulletin.facs.org/forums/forum/site-specific-data-items-grade-2018/general-instructions/139427-coding-the-grade-when-its-part-of-the-histology#post139441. In the example you provided, It appears the pathologist **did** assign a grade here because of the "(well diff)" statement.
19.	If a path report indicates that the tumor in the rectum lies completely below the peritoneal reflection, can we assume that that tumor is in the non-peritonealized rectum and code the case appropriately.	Yes. A tumor that lies below the peritoneal reflection is entirely non-peritonealized. This portion is the extraperitoneal rectum.
20.	Gross description in the path report only states that the entire tumor lies below the peritoneal reflection. It does not state if it is in the upper 1/3 of the rectum. I just wonder if, since it is below the peritoneal reflection, if that means that it is in the non-peritonealized portion of the rectum.	Yes. A tumor that lies below the peritoneal reflection is entirely non-peritonealized. This portion is the extraperitoneal rectum.
21.	Are these tables in a manual somewhere or did you design these yourself Denise?	The tables were designed by Denise, utilizing the information in the Manuals. They are for big-picture purposes only and to show an overview of what structures/LNs are regional versus distant by primary site/subsite.
22.	Not sure if 00 on Poll 7 is wrong - it's also reasonable to say 00 if LN not mentioned on CT report.	The code 000 would be appropriate per EOD Manual, instruction 8 for EOD Regional Nodes if the tumor was localized. However, Poll 7 refers to a non-

		localized tumor, so we will assign code 999 because the lymph nodes were not mentioned anywhere in the imaging report. This answer was confirmed by Jennifer Ruhl.
23.	Why don't they just say that if there is a T3/4? - always code as Blank?	That example was in Donna Gress last presentation at NCRA, and it is also in the AJCC Curriculum for Registrars lesson 9.
24.	I think there needs to be a webinar for just blank vs X.... ;)	Great suggestion.
25.	When you say the best code - are you saying this is the way to code this? Or are we able to code how we interpret it?	The goal is for all data items to be coded in a standardized fashion. During this presentation, we provided common coding scenarios that we all encounter daily. We did extensive research on each case example utilizing the manuals, latest presentations provided by the standard setters, and current CAnswer Forum posts to guide our decisions. The rationale was provided in the slides and during the presentation, in hopes that we could all interpret these common scenarios in the same unified way.
26.	I was taught to follow the MD staging if gray area- they know more than we do.....Has that changed? Do we only use if correct?	Physician staging can be incorrect too, no one is infallible. If you have information that directly conflicts with the physician-assigned stage and you know the information is incorrect, you should not assign that incorrect stage in the registry software. If you are intentionally NOT following the coding rules in the manuals, then you are personally contributing to compromising the data within the state and/or NCDB database. If possible, these types of issues should be brought up with your Cancer Committee. If it is not possible, a BLANK is best so as not to compromise the data submitted to the national databases.
27.	There is always the possibility that the physician has other info that we don't have.	Do the best you can with the information you have, reach out to the physicians, utilize your manuals, and if you have questions reach out to the appropriate standard setter for guidance.
28.	For poll 12, how do you know the polypectomy is assessing the entire tumor when there are no margins mentioned?	The information can be used for clinical staging and the margins don't matter. Clinical stage is used to plan further treatment and for international comparisons. It is not as precise as a pathological stage. If after resection it was found to be more extensive, then the pathological stage would reflect that.

29.	I think the problem is knowing if the physician has the information. Could you give us more knowledge on how to work out when the MD could or could not know?	This comes with experience and knowing your physicians. If you are unsure whether the physician has information to which you do not have access, it is best to use blank and document why in the text fields.
30.	Just because the patient in Poll 12 had a subsequent resection (perhaps based on uncertain margins...we don't know), we can't necessarily assume the polypectomy was diagnostic. Patients can have multiple surgical procedures after all, and STORE captures cumulative surgical coding. The polypectomy could be an incisional biopsy (diagnostic) or an excisional biopsy (surgical).	In Poll 12 we knew it was part of the diagnostic workup; therefore, the information can be utilized for clinical staging. If after resection or multiple resections it was found to be more extensive or the same, then the pathological stage would reflect that more precise information.
31.	This ambiguity is the reason I feel we should go back to only entering what the physician assigns.	There was a time when we only entered what the physician assigned into the database; it was a total disaster, and the data was unusable. Physicians often take liberties while assigning stage that do not always align with AJCC guidelines. Back in the days when we used staging forms, physicians would often copy the pathological stage from the pathologist, and use that as the clinical stage. Registry data is being utilized for research. We need to follow registrar instruction, which is to use AJCC rules and guidelines.
32.	For Poll 11, cT is cTx, but would cN be BLANK?	I would need to see what the CT said about the lymph nodes, we did not include that information in this poll.
33.	Thank you for the information. I just think this is so vague -if it's not documented - it cannot be justified 100% and that why there is so much division in the Poll answers.	It is a very subtle difference, the instructions have evolved over time, but I am learning to embrace the BLANK, as Denise said, "BLANK IS BEAUTIFUL".
34.	Just curious, why is HAMN/LAMN confined by/to the muscularis propria EOD 000/050 instead of vice versa?	I am not sure of the rationale for this; however, it likely has something to do with how the Summary Stage, EOD T, and EOD Stage Group are derived at the central registry.
35.	For Poll 11, if you replaced the staging CT with a staging EUS, would cT be BLANK?	I would have to see what the EUS stated. Rectal primaries are commonly evaluated by EUS, so if the EUS gave a depth of invasion, we could assign the cT based on that.

36.	Was there a notification of the change in thinking on staging?	In came on my radar in a CAnswer Forum Post dated 03-26-2021. http://cancerbulletin.facs.org/forums/forum/ajcc-tnm-staging-8th-edition/lower-gastrointestinal-tract-chapters-19-21/colon-and-rectum-chapter-20/114814-rectal-uncertain-clinical-t-and-group-stage
37.	For poll 12 though how do you know it didn't go further into the colon layers? It just feels like a scenario that fits better with cTx because the physician wouldn't know based on the polypectomy (not all layers are sampled)	Code what you know; at that time Adenocarcinoma arising in a serrated polyp invading the submucosa is a cT1. If later the case was found to be more extensive the information would be reflected in the path staging. Same as if a patient had a lumpectomy and it showed Tis… if after resection it came back as invasive, that information is reflected in the path stage.